FOR OHF USE

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2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0020206

Facility Name: Greenwood Manor Nursing Home

Address: 410 Fletcher (Number) Jerseyville (City) 62052 (Zip Code)

County: Jersey

Telephone Number: (618) 498-6427 **Fax #** (618) 639-3339

IDPA ID Number: 370973047001

Date of Initial License for Current Owners:

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code		X	Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Mary C. Kolkovich **Telephone Number:** (618) 498-6427

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/04 to 12/31/04 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) Mary C. Kolkovich

(Title) Administrator

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title) Dennis E. Ulrich, Certified Public Accountant

(Firm Name & Address) Scheffel & Company, P.C.
143 North Kansas St., Edwardsville, IL 62025

(Telephone) (618) 656-1206 Fax # (618) 656-3536

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Greenwood Manor Nursing Home # 0020206 Report Period Beginning: 01/01/04 Ending: 12/31/04

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	98	Skilled (SNF)	98	35,868	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	98	TOTALS	98	35,868	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	392		2,690	3,082	8
9	SNF/PED					9
10	ICF	20,270	6,509		26,779	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	20,662	6,509	2,690	29,861	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 83.25%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 01/28/74

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 14 and days of care provided 2,690

Medicare Intermediary ADMINISTAR

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [ ] NO [ ]

Tax Year: 12/31/04 Fiscal Year: 13/31/04

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Greenwood Manor Nursing Home # 0020206 Report Period Beginning: 01/01/04 Ending: 12/31/04

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	127,509	17,800	5,926	151,235		151,235		151,235			1
2	Food Purchase		133,947		133,947		133,947		133,947			2
3	Housekeeping	59,560	16,141		75,701		75,701		75,701			3
4	Laundry	66,777	28,127		94,904		94,904		94,904			4
5	Heat and Other Utilities			90,891	90,891		90,891		90,891			5
6	Maintenance	50,800		65,732	116,532		116,532		116,532			6
7	Other (specify):*											7
8	TOTAL General Services	304,646	196,015	162,549	663,210		663,210		663,210			8
	B. Health Care and Programs											
9	Medical Director			10,200	10,200		10,200		10,200			9
10	Nursing and Medical Records	1,057,200	249,058	112,062	1,418,320		1,418,320		1,418,320			10
10a	Therapy	87,234		28,106	115,340		115,340		115,340			10a
11	Activities	35,879	5,476	4,863	46,218		46,218		46,218			11
12	Social Services	38,018			38,018		38,018		38,018			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,218,331	254,534	155,231	1,628,096		1,628,096		1,628,096			16
	C. General Administration											
17	Administrative	46,514		3,482	49,996		49,996	(3,482)	46,514			17
18	Directors Fees											18
19	Professional Services			52,689	52,689		52,689	955	53,644			19
20	Dues, Fees, Subscriptions & Promotions			9,498	9,498		9,498	(2,995)	6,503			20
21	Clerical & General Office Expenses	46,201	22,400	33,131	101,732		101,732	414	102,146			21
22	Employee Benefits & Payroll Taxes			301,998	301,998		301,998		301,998			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,657	1,657		1,657		1,657			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			74,347	74,347		74,347		74,347			26
27	Other (specify):*											27
28	TOTAL General Administration	92,715	22,400	476,802	591,917		591,917	(5,108)	586,809			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,615,692	472,949	794,582	2,883,223		2,883,223	(5,108)	2,878,115			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Greenwood Manor Nursing Home #0020206 Report Period Beginning: 01/01/04 Ending: 12/31/04

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			17,896	17,896		17,896	32,331	50,227			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			53,449	53,449		53,449	(6,298)	47,151			32
33	Real Estate Taxes							34,544	34,544			33
34	Rent-Facility & Grounds			156,000	156,000		156,000	(156,000)				34
35	Rent-Equipment & Vehicles			1,706	1,706		1,706		1,706			35
36	Other (specify):*											36
37	**TOTAL Ownership**			229,051	229,051		229,051	(95,423)	133,628			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			55,154	55,154		55,154		55,154			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			55,154	55,154		55,154		55,154			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,615,692	472,949	1,078,787	3,167,428		3,167,428	(100,531)	3,066,897			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Greenwood Manor Nursing Home # 0020206 Report Period Beginning: 01/01/04 Ending: 12/31/04

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	11,113	30		9
10	Interest and Other Investment Income	(6,298)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(3,482)	17		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(677)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(2,318)	20		28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	$ (1,662)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(98,869)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	$ (98,869)		36
37	TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))	$ (100,531)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			$		47

Greenwood Manor Nursing Home

ID# 0020206

Report Period Beginning: 01/01/04

Ending: 12/31/04

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Greenwood Manor Nursing Home # 0020206 **Report Period Beginning:** 01/01/04 **Ending:** 12/31/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	(3,482)	0	0	0	0	0	0	0	0	0	0	(3,482)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	955	0	0	0	0	0	0	0	0	0	955	19
20	Fees, Subscriptions & Promotions	(2,995)	0	0	0	0	0	0	0	0	0	0	(2,995)	20
21	Clerical & General Office Expenses	0	414	0	0	0	0	0	0	0	0	0	414	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(6,477)	1,369	0	0	0	0	0	0	0	0	0	(5,108)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(6,477)	1,369	0	0	0	0	0	0	0	0	0	(5,108)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Greenwood Manor Nursing Home # 0020206 **Report Period Beginning:** 01/01/04 **Ending:** 12/31/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	11,113	21,218	0	0	0	0	0	0	0	0	0	32,331	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(6,298)	0	0	0	0	0	0	0	0	0	0	(6,298)	32
33	Real Estate Taxes	0	34,544	0	0	0	0	0	0	0	0	0	34,544	33
34	Rent-Facility & Grounds	0	(156,000)	0	0	0	0	0	0	0	0	0	(156,000)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	4,815	(100,238)	0	0	0	0	0	0	0	0	0	(95,423)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(1,662)	(98,869)	0	0	0	0	0	0	0	0	0	(100,531)	45

Facility Name & ID Number Greenwood Manor Nursing Home # 0020206 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Lawrence B. Plummer	100.0	Greenwood Manor West, Inc.	Jerseyville	Greenwood Manor Land Trust	Jerseyville	Rental

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	19	Professional	$	Greenwood Manor Land Trust	66.67%	$ 955	$ 955	1
2	V	30	Depreciation		Greenwood Manor Land Trust	66.67%	21,218	21,218	2
3	V	33	Real Estate Taxes		Greenwood Manor Land Trust	66.67%	34,544	34,544	3
4	V	34	Rent	156,000	Greenwood Manor Land Trust	66.67%		(156,000)	4
5	V	21	General Administrative		Greenwood Manor Land Trust	66.67%	414	414	5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 156,000			$ 57,131	$ * (98,869)	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number Greenwood Manor Nursing Home # 0020206 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Barbara Molloy	Asst. Administrator	Administration	0.00	11,612	10	20.00	Wages	$ 8,091	17-1	1
2	Lawrence B. Plummer	Medical Director	Medical Director	100.00		8	100.00	Fees	1,200	9-3	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 9,291		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Greenwood Manor Nursing Home # 0020206 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Greenwood Manor Nursing Home # 0020206 Report Period Beginning: 01/01/04 Ending: 12/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	White Hall National Bank		X	Operating Loan Consolidation		8/1/03	$ 450,000	$ 423,647	8/1/2018	5.6500	$ 26,616	1
2												2
3												3
4												4
5												5
	Working Capital											
6	White Hall National Bank		X	Operating Line of Credit		Various	Various	499,672		5.9500	26,833	6
7												7
8												8
9	TOTAL Facility Related						$ 450,000	$ 923,319			$ 53,449	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 450,000	$ 923,319			$ 53,449	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Greenwood Manor Nursing Home # 0020206 Report Period Beginning: 01/01/04 Ending: 12/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2003 report.	$		1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	34,544	2
3. Under or (over) accrual (line 2 minus line 1).	$	34,544	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)	$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	34,544	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1999	25,880	8
	2000	25,489	9
	2001	29,526	10
	2002	29,526	11
	2003	32,799	12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Greenwood Manor Nursing Home COUNTY Jersey

FACILITY IDPH LICENSE NUMBER 0020206

CONTACT PERSON REGARDING THIS REPORT Mary C. Kolkovich, Administrator

TELEPHONE (618) 498-6427 FAX #: (618) 639-3339

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	04-208-024-00	S28 T8 R11 Jersey Township	$ 34,544.00	$ 34,544.00
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 34,544.00	$ 34,544.00

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

Facility Name & ID Number Greenwood Manor Nursing Home # 0020206 Report Period Beginning: 01/01/04 Ending: 12/31/04

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 22,627 B. General Construction Type: Exterior Brick Frame Wood Number of Stories One

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	To accommodate Bldg.		1973	$ 15,000	1
2	and Parking	153,475	1981	1,267	2
3	TOTALS	153,475		$ 16,267	3

Facility Name & ID Number Greenwood Manor Nursing Home # 0020206 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	98		1974	1974	$ 775,750	$ 19,394	40	$ 19,394	$	$ 601,207	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Sewer			1974	28,540		10			28,540	9
10	Air Conditioner			1980	8,000		8			8,000	10
11	Air Conditioner			1981	8,000		5			8,000	11
12	Air Conditioner			1982	1,387		5			1,387	12
13	Air Conditioner			1983	2,323		5			2,323	13
14	Wiring			1983	1,760		7			1,760	14
15	Additional Parking			1984	2,050		15			2,050	15
16	Air Conditioner			1984	1,241		5			1,241	16
17	Painting/Wallpaper			1981	3,520		8			3,520	17
18	Ice Machine			1981	1,308		5			1,308	18
19	Building Repair			1981	1,560		5			1,560	19
20	Redecorating Rooms			1981	14,804		7			14,804	20
21	Lighting			1986	3,206		20	160	160	3,072	21
22	Air Conditioner			1986	1,329		8			1,329	22
23	Air Conditioner			1986	3,775		8			3,775	23
24	New Walls			1986	1,318		20	66	66	1,208	24
25	Roof			1987	29,000	935	30	967	32	16,434	25
26	Cabinets			1988	1,045		20	52	52	853	26
27	Water heater			1988	3,375		15			3,375	27
28	Smoke Alarms			1988	2,764		20	138	138	2,234	28
29	Smoke Alarms			1988	5,380		20	269	269	4,304	29
30	Water Softner			1989	6,225		15	415	415	6,225	30
31	Handicap Drinking Fountain			1990	1,794		15	120	120	1,745	31
32	Compressor for Air Conditioner			1990	1,194		8			1,194	32
33	Privacy Curtains & Tracks			1991	3,675		10			3,675	33
34	Landscaping			1992	1,500	89	10		(89)	1,500	34
35	Carpeting			1995	16,083		10	1,608	1,608	14,608	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Greenwood Manor Nursing Home # 0020206 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Fencing	1996	$ 1,400	$	15	$ 93	$ 93	$ 801	37
38	Roof	1988	30,138	972	30	1,005	33	16,325	38
39	Building Improvements	1989	19,293	622	30	643	21	9,861	39
40	Window Covering	1990	1,558		10			1,558	40
41	Air Conditioners	1989	2,557		8			2,557	41
42	Light Posts & Lights	1990	1,080		15	72	72	1,056	42
43	New Ductwork	1990	2,983	96	20	149	53	2,163	43
44	Rubrails & Wall Guards	1990	5,038		10			5,038	44
45	Curtain & Tracks	1990	2,859		10			2,859	45
46	Building Improvemetns	1990	47,877		30	1,596	1,596	23,141	46
47	Hand Rails	1990	3,409		10			3,409	47
48	Cubicle Curtains	1991	2,150		10			2,150	48
49	Privacy Curtains/Tracks	1991	8,576		10			8,576	49
50	Kitchen Floor	1991	2,820		10			2,820	50
51	Privacy Curtains/Tracks	1991	5,763		10			5,763	51
52	Room Air Conditioner	1991	1,403		8			1,403	52
53	Hand Rails	1991	5,944		10			5,944	53
54	Building Improvements	1991	5,358		15	357	357	4,822	54
55	Landscaping	1992	2,691	159	10		(159)	2,691	55
56	Air Conditioner - Roof Top	1992	26,075	841	20	1,304	463	16,080	56
57	Wallpaper & Cove	1992	1,768		10			1,768	57
58	Sprinkler System	1993	1,399	35	25	56	21	662	58
59	Ceiling Fan	1993	349		15	23	23	259	59
60	Windows	1993	3,750	94	15	250	156	2,771	60
61	Windows	1994	7,050	176	30	181	5	1,981	61
62	Windows	1994	5,800	145	30	149	4	1,605	62
63	Windows	1994	216	5	30	6	1	59	63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,131,210	$ 23,563		$ 29,073	$ 5,510	$ 869,353	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Greenwood Manor Nursing Home # 0020206 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 1,131,210	$ 23,563		$ 29,073	$ 5,510	$ 869,353	1
2	Air Conditioner	1994	1,574		8			1,574	2
3	Call Lights	1994	3,132		15	209	209	2,158	3
4	Door control Systme	1994	891		15	59	59	604	4
5	Call Light System	1995	6,607		15	441	441	4,406	5
6	Door Alarm System	1995	2,252		15	150	150	1,501	6
7	Call Lights	1995	791		15	53	53	519	7
8	Windows	1996	12,187	305	30	406	101	3,487	8
9	Nurses Station	1996	6,760	169	20	338	169	2,789	9
10	Remodel	1997	3,360	84	39	86	2	682	10
11	Shower Room	1998	19,285	482	40	482		3,053	11
12	Roof	1998	10,000	250	40	250		1,583	12
13	Roof	1999	75,469	1,887	40	1,887		11,321	13
14	Remodel - Kitchen Walls, Floor	2000	6,500	163	40	163		691	14
15	Smoking Shed - Electrical (Metal)	2001	768	59	20	38	(21)	137	15
16	3 Fire/Smoke Dampers	2002	2,904	356	10	290	(66)	847	16
17	New A/C Compressor	2002	1,495	183	10	149	(34)	398	17
18	New A/C thru-the-wall unit	2002	1,462	179	10	146	(33)	365	18
19	80 gal Water Heater	2002	5,000	612	10	500	(112)	1,250	19
20	Carrier Air Conditioner	2002	1,585	194	10	158	(36)	396	20
21	A/C Fan Motor A-14	2002	526	64	5	105	41	237	21
22	New A/C thru-the-wall unit A-6	2002	1,459	179	10	146	(33)	328	22
23	Fire Alarm System Upgrade	2002	3,296	197	10	330	133	742	23
24	Maintenance Shed	2002	1,410	84	20	71	(13)	177	24
25	Front Parking Lot Repair	2002	12,864	800	8	1,608	808	3,618	25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,312,787	$ 29,810		$ 37,138	$ 7,328	$ 912,216	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Greenwood Manor Nursing Home # 0020206 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 139,849	$ 4,576	$ 12,582	$ 8,006		$ 90,303	71
72	Current Year Purchases	8,071	4,728	507	(4,221)		507	72
73	Fully Depreciated Assets	374,097					374,097	73
74								74
75	TOTALS	$ 522,017	$ 9,304	$ 13,089	$ 3,785		$ 464,907	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 1,851,071	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 39,114	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 50,227	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 11,113	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,377,123	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Greenwood Manor Nursing Home # 0020206 Report Period Beginning: 01/01/04 Ending: 12/31/04

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO
16. Rental Amount for movable equipment: $ 1,998 Description: $894 Postage Meter, $295 Pager Rental, $809 Dishwasher Rental
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Greenwood Manor Nursing Home # 0020206 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number Greenwood Manor Nursing Home # 0020206 Report Period Beginning: 01/01/04 Ending: 12/31/04

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/04 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	642,479	642,479	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	24,492	24,492	7
8	Accounts Receivable (owners or related parties)	687,791	653,120	8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,354,762	$ 1,320,091	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	680,681	680,681	12
13	Land		16,267	13
14	Buildings, at Historical Cost		852,569	14
15	Leasehold Improvements, at Historical Cost	309,973	336,028	15
16	Equipment, at Historical Cost	521,533	567,887	16
17	Accumulated Depreciation (book methods)	(647,329)	(1,375,532)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 864,858	$ 1,077,900	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,219,620	$ 2,397,991	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 398,630	$ 398,431	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	521,586	521,586	29
30	Accrued Salaries Payable	22,227	22,227	30
31	Accrued Taxes Payable (excluding real estate taxes)	39,553	39,553	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 981,996	$ 981,797	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	401,733	401,733	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 401,733	$ 401,733	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,383,729	$ 1,383,530	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 835,891	$ 1,014,461	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,219,620	$ 2,397,991	48

*(See instructions.)

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 865,602	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 865,602	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(29,711)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (29,711)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 835,891	24 *

*** This must agree with page 17, line 47.**

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XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,098,496	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,098,496	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	6,298	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 6,298	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Investment Income	32,923	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 32,923	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,137,717	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	663,210	31
32	Health Care	1,628,096	32
33	General Administration	591,917	33
	B. Capital Expense		
34	Ownership	229,051	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	55,154	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,167,428	40
41	**Income before Income Taxes (line 30 minus line 40)****	(29,711)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (29,711)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? No,cash basis If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

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XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,904	1,606	$ 39,967	$ 24.89	1
2	Assistant Director of Nursing					2
3	Registered Nurses	8,798	8,836	178,397	20.19	3
4	Licensed Practical Nurses	10,111	10,760	144,398	13.42	4
5	Nurse Aides & Orderlies	64,966	67,421	591,278	8.77	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,781	5,086	87,234	17.15	8
9	Activity Director	1,847	2,031	18,178	8.95	9
10	Activity Assistants	1,829	2,014	17,701	8.79	10
11	Social Service Workers	4,231	3,441	38,018	11.05	11
12	Dietician					12
13	Food Service Supervisor	1,960	2,081	23,100	11.10	13
14	Head Cook	8,537	6,283	46,748	7.44	14
15	Cook Helpers/Assistants	5,477	5,793	38,526	6.65	15
16	Dishwashers	2,023	2,802	19,135	6.83	16
17	Maintenance Workers	3,973	4,265	50,800	11.91	17
18	Housekeepers	6,817	7,626	59,560	7.81	18
19	Laundry	10,276	10,042	66,777	6.65	19
20	Administrator	2,080	2,080	38,423	18.47	20
21	Assistant Administrator	592	577	8,091	14.02	21
22	Other Administrative					22
23	Office Manager	1,920	2,080	24,217	11.64	23
24	Clerical	1,960	2,080	21,984	10.57	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health C: Resident Aides	13,244	14,489	103,160	7.12	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	158,326	161,393	$ 1,615,692 *	$ 10.01	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	136	$ 5,926	1-3	35
36	Medical Director		10,200	9-3	36
37	Medical Records Consultant	64	2,232	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	varies	1,920	10-3	39
40	Physical Therapy Consultant	83	5,040	10a-3	40
41	Occupational Therapy Consultant	2	53	10a-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	11	570	10a-3	43
44	Activity Consultant	86	4,863	11-3	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	382	$ 30,804		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses	1,764	52,993	10-3	51
52	Nurse Aides	2,604	51,968	10-3	52
53	TOTAL (lines 50 - 52)	4,368	$ 104,961		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Mary Kolkovich	Administrator	0	$ 38,423
Barbara Molloy	Asst. Administrator	0	8,091
TOTAL (agree to Schedule V, line 17, col. 1)			$ 46,514
(List each licensed administrator separately.)			

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Paychex	Payroll	$ 4,957
Automated Data Processing	Payroll	1,984
Scheffel & Company	Accounting	33,195
Stratton, Giganti, Stone	Legal	8,232
McMahon, Berger, Professional	Legal	695
Farrell, Hunter, Hamilton	Legal	80
Ross Breitweiser	Computers	600
American Express Tax	Other Professional	1,800
Circle of Quality	Other Professional	1,146
TOTAL (agree to Schedule V, line 19, column 3)		$ 52,689
(If total legal fees exceed $2500 attach copy of invoices.)		

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 100,332
Unemployment Compensation Insurance	28,915
FICA Taxes	119,889
Employee Health Insurance	47,513
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Employee Benefits	4,879
Employee Physicals	470
TOTAL (agree to Schedule V, line 22, col.8)	$ 301,998

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	5,137
Health Care Worker Background Check	
(Indicate # of checks performed 78)	614
Dues & Subscriptions	752
Advertising & Promotions	2,995
Less: Public Relations Expense	(677)
Non-allowable advertising	( )
Yellow page advertising	(2,318)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 6,503

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,657
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,657

**See instructions.

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XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Greenwood Manor Nursing Home # 0020206 Report Period Beginning: 01/01/04 Ending: 12/31/04

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? NO

(2) Are there any dues to nursing home associations included on the cost report? NO
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 7

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ disposable only $7,352 Line 10-2

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. N/A

(9) Are you presently operating under a sublease agreement? YES X NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ 55,154
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ NONE Has any meal income been offset against related costs? NONE Indicate the amount. $ N/A

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. $ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 0%
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ 0

(17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. N/A

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? YES

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees.